NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

MH/DD/SAS Community Systems Progress Report

Third Quarter SFY 2007-2008

January 1 – March 31, 2008

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Community Policy Management Section
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

May 30, 2008

Quality
NC DMH/DD/SAS

Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives.

-- William A. Foster. Quotations. Quotations Book, 2005.

Highlights of Third Quarter SFY 2007-2008

New Measure! Timely Access to Care

- According to data reported to the Division from the Local Management Entities (LMEs), 98% of individuals determined to need emergent care were provided a face-to-face service (assessment and/or treatment) within two hours from the time of the request. Another one percent had a provider on-site within two hours ready to give care when the individual was available. This falls one percent short of the SFY 2008 target of 100% of individuals receiving a service within two hours of the request.
- LMEs reported that 79% of individuals determined to need urgent care were provided a face-to-face service within 48 hours from the time of the request (failing to meet the SFY 2008 target of 88%).
- Almost two-thirds (66%) of individuals determined to need routine care were provided a face-to-face service within 14 calendar days from the time of the request, which is three percent below the SFY 2008 target of 69%.

Services to Persons in Need

- Mental health consumers receiving federal or state funded services in their communities reached the SFY 2008 target for adults (39% served) and exceeded the target set for children with 45% served compared to the target of 38 percent. Since the second quarter report, adult mental health consumers receiving services increased one percent and children/adolescents increased two percent.
- Developmental disability consumers receiving federal or state funded services in their communities exceeded the SFY 2008 target for adults by one percent (37% served) and reached the target set for children (19% served). While there was no change in child developmental disability consumers since the second quarter report, services to adults increased one percent.
- Services to adult and child substance abuse consumers fell short (by 3% each) of the SFY 2008 target (7% and 6% served, respectively), with no progress made since last quarter's report.

Timely Initiation and Engagement in Service

- Statewide, the SFY 2008 target for initiation of mental health consumers into care was not met this quarter (fell short by 4%) with only 38% of consumers receiving 2 visits within the first 14 days of care; however, this represents an increase of one percent from the second quarter report. The SFY 2008 target for engagement of these consumers was met in the third quarter, and also represents an increase of one percent since the last report.
- The SFY 2008 target for initiation of developmental disability consumers into care was not met in the third quarter. Seventy percent of these consumers received 2 visits within the first 14 days of care, just shy of the 72% target. However, the SFY 2008 target for engagement of developmental disability consumers was exceeded with 59% of developmental disability consumers having had 4 visits within 45 days of care (compared to the 55% target). Both initiation and engagement of developmental disability consumers saw a significant increase since last quarter's report (8% respectively).

- The SFY 2008 target for initiation of substance abuse consumers into care was not met this quarter. Sixty-four percent of these consumers received 2 visits within the first 14 days of care (compared to the 71% target). However, the SFY 2008 target for engagement of substance abuse consumers was met with 50% of substance abuse consumers having had 4 visits within 45 days of care. While there was no change in the initiation of substance abuse consumers into services since last quarter's report, engagement of these consumers rose three percent.

Effective Use of State Psychiatric Hospitals

- Consumers receiving short term care (up to 7 days of care) in state psychiatric hospitals did not meet the SFY 2008 target; in fact, at 52% of consumers having stays of a week or less, this measure was 8% over the SFY 2008 target of 44% or less of consumers admitted to state psychiatric hospitals for stays of 7 days or less. However, some progress has been made and short term stays are down two percent from the second quarter's report.

New Measure! State Psychiatric Hospital Readmissions

- Across the state, ten percent of consumers discharged from a state psychiatric hospital were readmitted within 1 to 30 days. Within 1 to 180 days, 23% of consumers were readmitted. Both of these measures failed to meet the SFY 2008 target of 8% or fewer readmitted within 30 days and 16% or fewer readmitted within 180 days.

Timely Follow-Up after Inpatient Care

- The SFY 2008 targets for follow-up care for consumers discharged from ADATCs or state psychiatric hospitals were not met this quarter (21% and 33% of consumers seen in 1 to 7 days, respectively). Follow-up care for consumers discharged from ADATCs fell 5% from the second quarter's report. In addition, follow-up care for consumers discharged from state hospitals fell two percent since last quarter's report.

New Measure! Child Services in Non-Family Settings

- Only four percent of children and adolescents receiving mental health and/or substance abuse services were served in non-family settings, exceeding the SFY08 target of five percent or less.

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Introduction

Tracking the effectiveness of community systems provides a means for the public and General Assembly to hold the Division of MH/DD/SAS, the LMEs, and provider agencies accountable for progress toward the goals of the system reform.[1] Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities.

Each topic covered by these indicators involves substantial "behind-the-scenes" activity by service providers, LME and state staff, consumers, and family members. These indicators do not purport to cover all of those efforts. Instead, they address the desired results of those activities as a way to guide decisions about more detailed analysis by system stakeholders into issues that affect progress toward the goals of MH/DD/SAS system transformation. The indicators were chosen to reflect:

- accepted standards of care,
- fair and reliable measures, and
- readily available data sources.

The following pages present graphs showing the progress of each LME on the selected indicators for the most recent time period available.[2] Measures relying on service claims data are delayed by 90 to 180 days to allow time for claims to be processed.[3] The source information below each graph provides details on the data systems and time periods used.

Formulas for calculating the indicators as well as tables showing the statistics for each LME on all indicators are available in a separate document, the *Appendices for MH/DD/SAS Community Systems Progress Report.* Both are available on the Division website at:

http://www.ncdhhs.gov/mhddsas/statspublications/reports

For SFY 2007-2008, the Division has redesigned the Community Systems Progress Report to include statewide targets to be achieved by the end of the fiscal year. These targets are indicated by a red line across the graphs on the following pages. The Division has set higher targets for areas of greatest concern, notably seeking the greatest improvements in substance abuse services and in decreased use of state psychiatric hospitals.

The indicators and targets in this report mirror topics chosen as performance measures for the SFY 2007-2008 DHHS-LME Performance Contract. Performance standards required by the Contract are noted at the bottom of each graph. However, the emphasis of the Community Systems Progress Reports remains on highlighting gains made toward desired results rather than compliance with basic requirements. For this reason, a text box has been added to each graph

[1] This report fulfills the requirements of S.L. 2006-142 (HB 2077) that directs the Department of Health and Human Services to develop critical indicators of LME performance. Measures reflect the goals of the NC State Plans 2000-2006, the President's New Freedom Initiative, CMS' Quality Framework for Home and Community Based Services, and SAMHSA's Federal Action Agenda and National Outcome Measures.

[2] A list of counties that make up each LME is available in the Report Appendix.

[3] Data on service claims for Piedmont are not available for this report and noted by an asterisk in graphs where applicable.

that highlights the number of LMEs that achieved the fiscal year target during the reporting period.

The Division added three additional indicators this quarter that are important to tracking progress in the community system. These three new indicators are:

- ***Readmissions to State Psychiatric Hospitals***

  Successful community living, without repeated admissions to inpatient psychiatric care, requires effective coordination and ongoing appropriate levels of community care after hospitalization. A low psychiatric hospital readmission rate is a nationally accepted standard of care that indicates how well a community is assisting individuals at risk for repeated hospitalizations.

  The Division uses data from the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) on discharges from the psychiatric hospitals to calculate the number of discharges with a readmission within the reported time period (30 days and 180 days).

- ***Timely Access To Services***

  When an individual makes a request for service, quick response with the appropriate level of care is a gauge of the system's service capacity and coordination efforts. The Division's standards for access include providing care within two hours of request in emergent situations, within 48 hours in urgent situations, and within 14 calendar days in routine situations.

  The Division is currently using data from LME quarterly reports for this measure, but future reports will utilize data LMEs are submitting to the Division's Consumer Data Warehouse on all persons requesting services. This data will be matched to service claims data to determine the percent of persons who received necessary emergent services within 2 hours of request, urgent services within 48 hours, and routine services within 14 calendar days.

- ***Child Services in Family Settings***

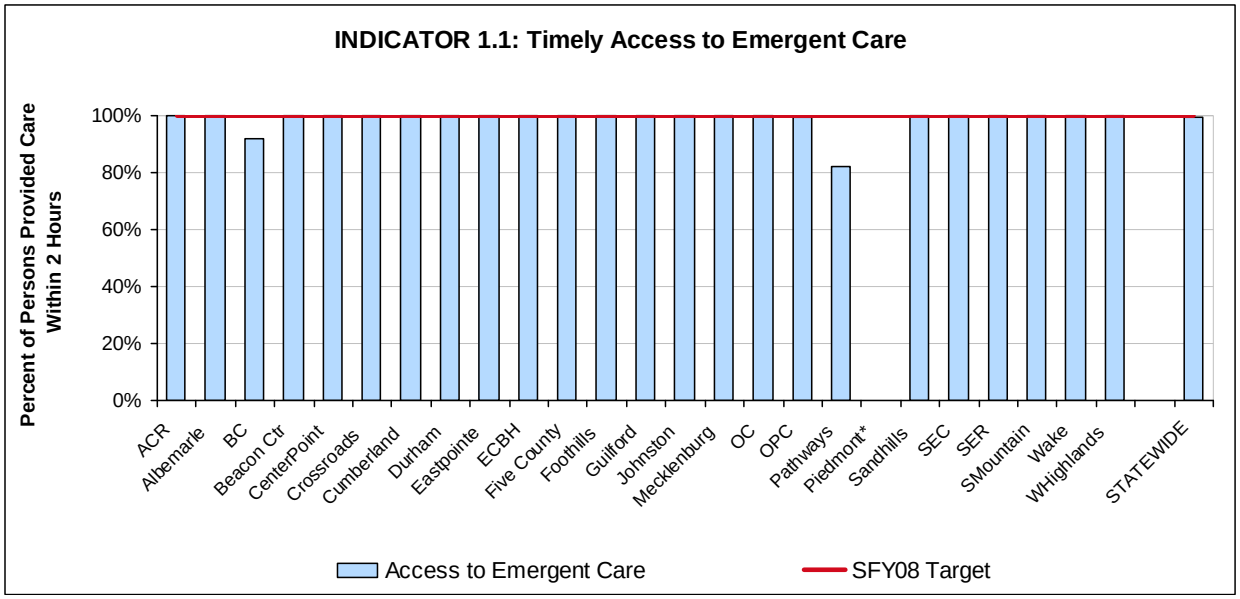
  Services provided in a child's home community, particularly in a family setting, promote the achievement of long-term stability that comes from a sense of belonging. Children and adolescents served in the most natural and least restrictive community settings appropriate to their needs are more likely to maintain or develop positive family and community connections and to achieve other lasting, positive outcomes.

  The Division uses service claims data to calculate the number of children and adolescents in each LME who receive Level II (Program-type only), Level III and/or Level IV residential services as a percent of all children and adolescents served by the LME during the reported quarter. The goal is to reduce the percent of children and adolescents served in these settings over time, while increasing those served while living with their natural families, foster families, or with therapeutic foster families (Level II Family-type residential services).

Indicator 1: Timely Access to Care

1.1 Emergent Care

Rationale: Timely access to appropriate care is critical to protect consumer health and safety, minimize adverse consumer outcomes and promote consumer engagement in services. The timely access measures are based on Healthcare Enterprise Data Information System (HEDIS ©) measures, supported by the federal Centers for Medicaid and Medicare.



SOURCE: LME data reported to DMH/DD/SAS. January 1 - March 31, 2008; N=8,197 persons in need

Statewide, according to LME self-report data, 99% of persons determined to need emergent care had a provider on-site within two hours of the time of the request, ready to give care once the individual was available. Of those, 98% were provided federal or state funded services through our community service system within that time frame (see Appendix for details).

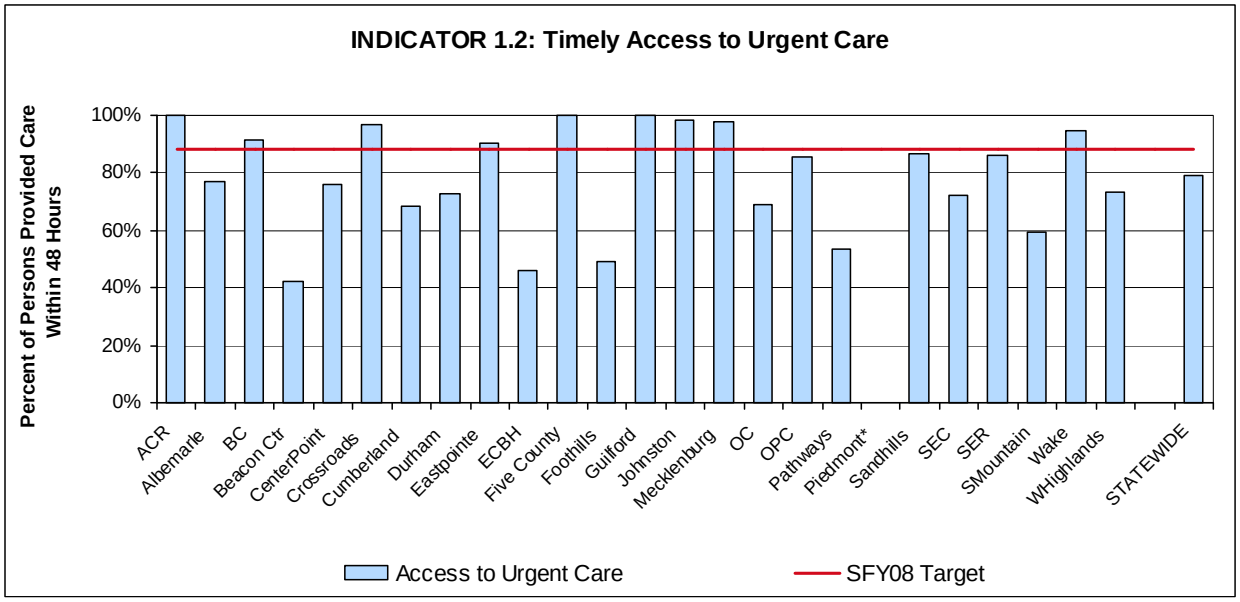
The established SFY 2008 target for access to emergent care is 100%, as indicated by the red line in the graph above[4]. Of the 24 LMEs reporting, 22 LMEs met the target.

[4] The SFY 2008 DHHS-LME Performance Contract requirement is 100%.

Indicator 1: Timely Access to Care

1.2 Urgent Care

Rationale: Timely access to appropriate care is critical to protect consumer health and safety, minimize adverse consumer outcomes and promote consumer engagement in services. The timely access measures are based on Healthcare Enterprise Data Information System (HEDIS ©) measures, supported by the federal Centers for Medicaid and Medicare.



SOURCE: LME data reported to DMH/DD/SAS. January 1 - March 31, 2008; N=5,950 persons in need

Statewide, according to LME self-report data, 79% of persons determined to need urgent care were provided federal or state funded services through our community service system within 48 hours from the time of the request. The rate of persons who were served within the 48-hour period varied among LMEs from a low of 42% (Beacon Center) to a high of 100% (Alamance-Caswell-Rockingham, Five County, and Guilford).

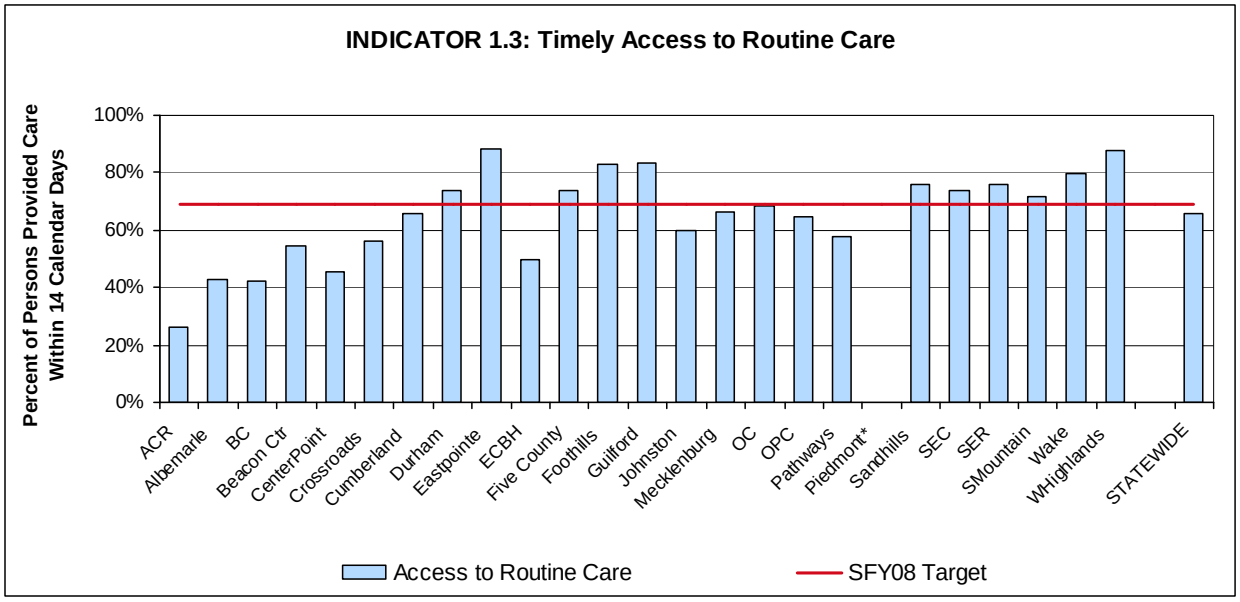
The established SFY 2008 target for access to urgent care is 88%, as indicated by the red line in the graph above[5]. Of the 24 LMEs reporting, just over one-third of the LMEs (9 LMEs) met or exceeded the target.

[5] The SFY 2008 DHHS-LME Performance Contract requirement is 80% or above.

Indicator 1: Timely Access to Care

1.3 Routine Care

Rationale: Timely access to appropriate care is critical to protect consumer health and safety, minimize adverse consumer outcomes and promote consumer engagement in services. The timely access measures are based on Healthcare Enterprise Data Information System (HEDIS ©) measures, supported by the federal Centers for Medicaid and Medicare.



SOURCE: LME data reported to DMH/DD/SAS. January 1 - March 31, 2008; N=27,864 persons in need

Approximately two-thirds (66%) of persons determined to need urgent care were provided federal or state funded services through our community service system within 14 calendar days from the time of the request. The rate of persons who were served within the 14-day period varied among LMEs from a low of 26% (Alamance-Caswell-Rockingham) to a high of 88% (Eastpointe and Western Highlands).

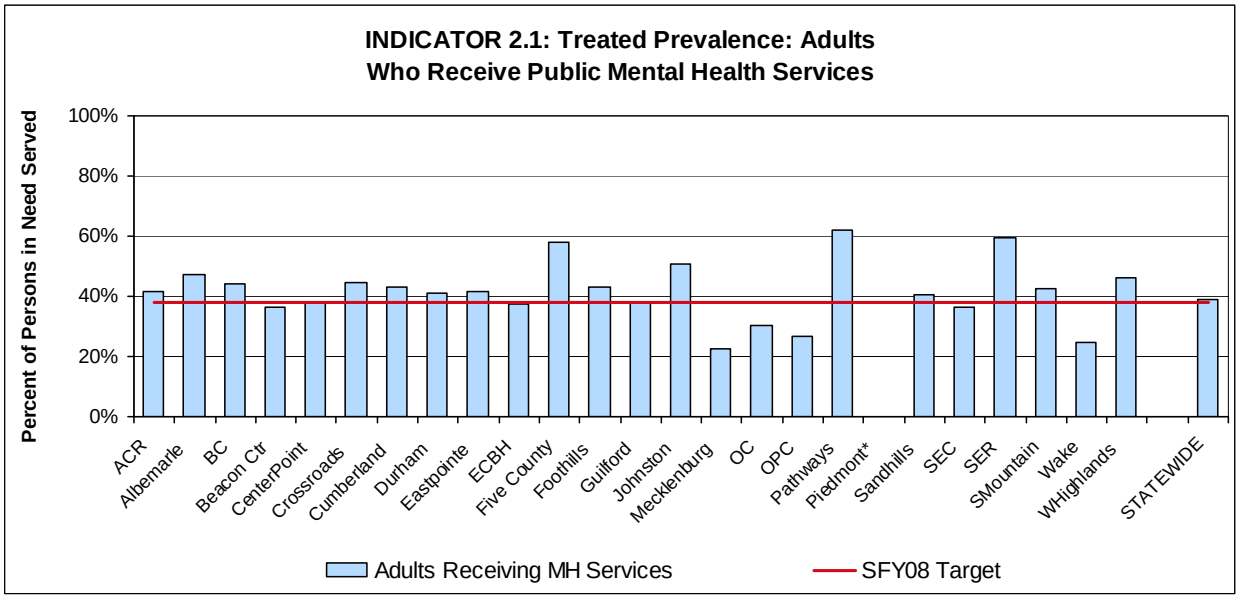
The established SFY 2008 target for access to urgent care is 69%, as indicated by the red line in the graph above[6]. Of the 24 LMEs reporting, half of the LMEs (12 LMEs) met or exceeded the target.

[6] The SFY 2008 DHHS-LME Performance Contract requirement is 63% or above.

Indicator 2: Services to Persons in Need

2.1 Adult Mental Health Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This indicator is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. January 1- December 31, 2007; N=342,218 adults in need

Statewide, 133,429 adults (39% of those in need of services[7]) received federal or state funded MH services through our community service system from January through December 2007.[8] The rate of adults who were served varied among LMEs from a low of 22% (Mecklenburg) to a high of 62% (Pathways).

The established SFY 2008 target for persons receiving adult mental health services is 38% or higher, as indicated by the red line in the graph above[9]. Of the 24 LMEs reporting, 18 LMEs met or exceeded the target.

[7] URS Table 1: Number of Persons with Serious Mental Illness [*sic*], age 18 and older, by State, 2006, Civilian Population with SMI (5.4%). Prepared by NRI/SDICC for CMHS: June 14, 2007. Estimates applied to county population as of July 2007.

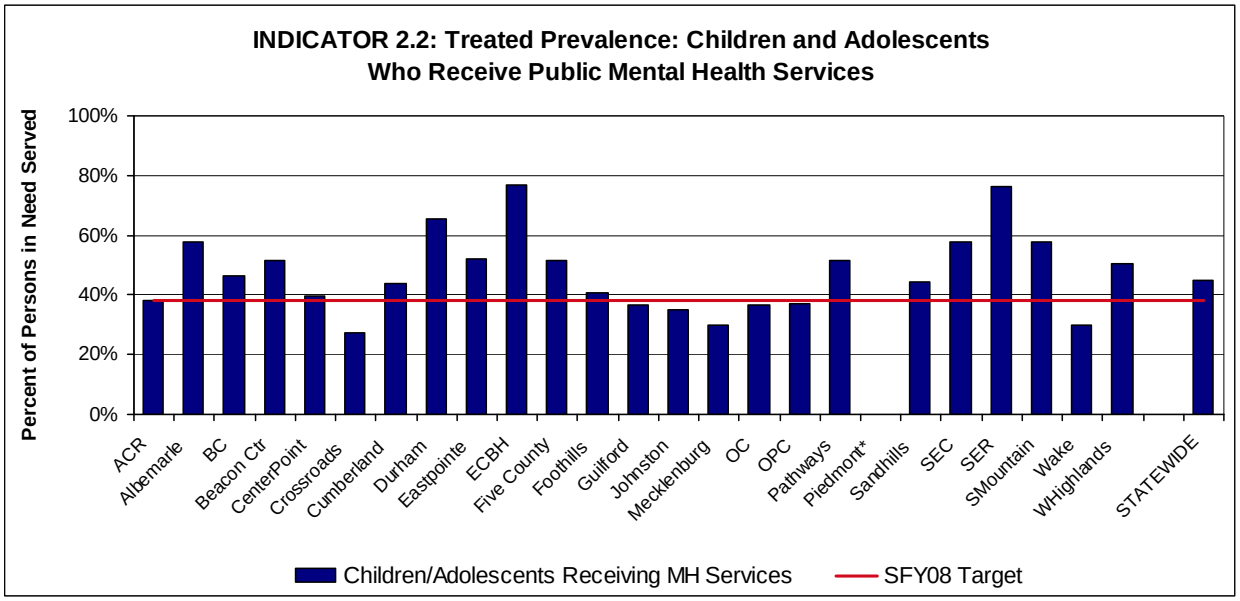
[8] The numbers served reflect adults, ages 18 and over, who received any MH services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private funds. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[9] The SFY 2008 DHHS-LME Performance Contract requirement is 38% or above.

Indicator 2: Services to Persons in Need

2.2 Child and Adolescent Mental Health Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. January 1- December 31, 2007; N=201,155 children and adolescents in need

Statewide, 90,457 children and adolescents (45% of those in need of services[10]) received federal or state funded MH services through our community service system from January through December 2007.[11] The rate of those served varied from a low of 27% (Crossroads) to a high of 77% (ECBH).

The established SFY 2008 target for persons receiving child mental health services is 38%, as indicated by the red line in the graph above[12]. Of the 24 LMEs reporting, 17 LMEs met or exceeded the target.

[10] URS Table 1: Number of Children with Serious Emotional Disturbances [*sic*], age 9 to 17, by State, 2006, Level of functioning score=60, midpoint of range between lower and upper limits of estimates. Prepared by NRI/SDICC for CMHS: August 30, 2007. The Division applies the estimates established by CMHS for children ages 9-17 to those under the age of 9, since no established estimates exist for younger children. Estimates applied to county population as of July 2007.

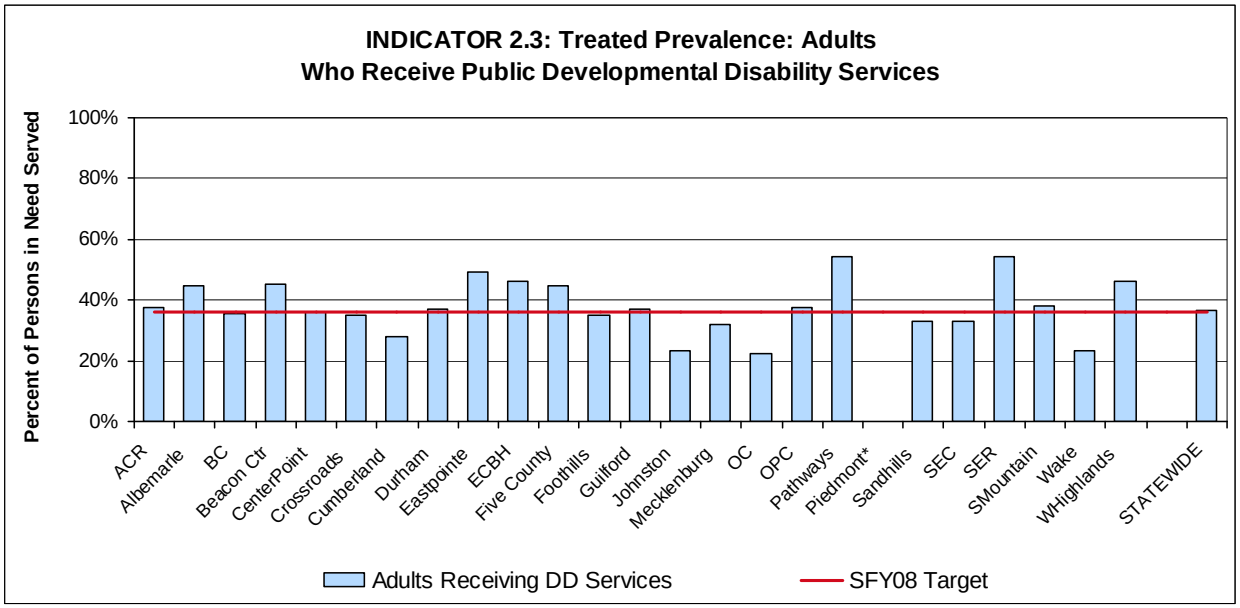
[11] The numbers served reflect children and adolescents, ages 3-17, who received any MH services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private funds. The NC Division of Public Health is responsible for all services from birth through age 2. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[12] The SFY 2008 DHHS-LME Performance Contract requirement is 38% or above.

Indicator 2: Services to Persons in Need

2.3 Adult Developmental Disability Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. January 1- December 31, 2007; N=50,008 adults in need

Statewide, 18,381 adults (37% of those in need of services[13]) received federal or state funded DD services through our community service system from January through December 2007.[14] The rate of adults who were served varied among LMEs from a low of 22% (Onslow-Carteret) to a high of 54% (Pathways and Southeastern Regional).

The established SFY 2008 target for persons receiving adult developmental disability services is 36%, as indicated by the red line in the graph above[15]. Of the 24 LMEs reporting, 14 LMEs met or exceeded the target.

[13] Fact Sheet 2: Estimated Ages of People with MR/DD in US Non-Institutional Population from the 1994 and 1995 National Health Interview Survey (NHIS), http://rtc.umn.edu/docs/fs0102.html. Prevalence rates for persons ages 3-5 = 3.8%, ages 6-16 = 3.2%, ages 17-24 = 1.5%, ages 25-34 = 0.9%, ages 35-44 = 0.8%, ages 45-54 = 0.7%, ages 55-64 = 0.5%, ages 65and older = 0.4%. Age appropriate estimates applied to county population as of July 2007 (See *Appendix*).

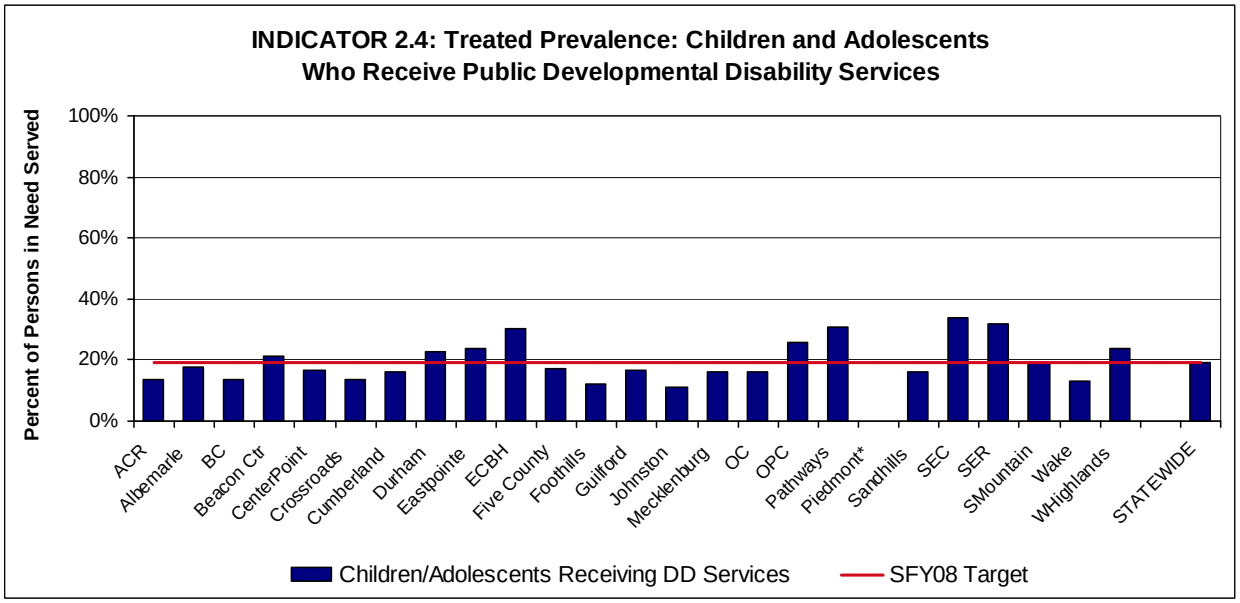
[14] The numbers served reflect adults, ages 18 and over, who received any DD services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private sources. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[15] The SFY 2008 DHHS-LME Performance Contract requirement is 36% or above.

Indicator 2: Services to Persons in Need

2.4 Child and Adolescent Developmental Disability Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. January 1- December 31, 2007; N=53,737 adolescents in need

Statewide, 10,410 children and adolescents (19% of those in need of services[16]) received federal or state funded DD services through our community service system from January through December 2007.[17] [18] The rate of those who were served varied among LMEs from a low of 11% (Johnston) to a high of 34% (Southeastern Center).

The established SFY 2008 target for persons receiving child developmental disability services is 19%, as indicated by the red line in the graph above[1]. Of the 24 LMEs reporting, almost half of the LMEs (11 LMEs) met or exceeded the target.

[16] Fact Sheet 2: Estimated Ages of People with MR/DD in US Non-Institutional Population from the 1994 and 1995 National Health Interview Survey (NHIS), http://rtc.umn.edu/docs/fs0102.html. Age appropriate estimates applied to county population as of July 2007 (See *Appendix*).

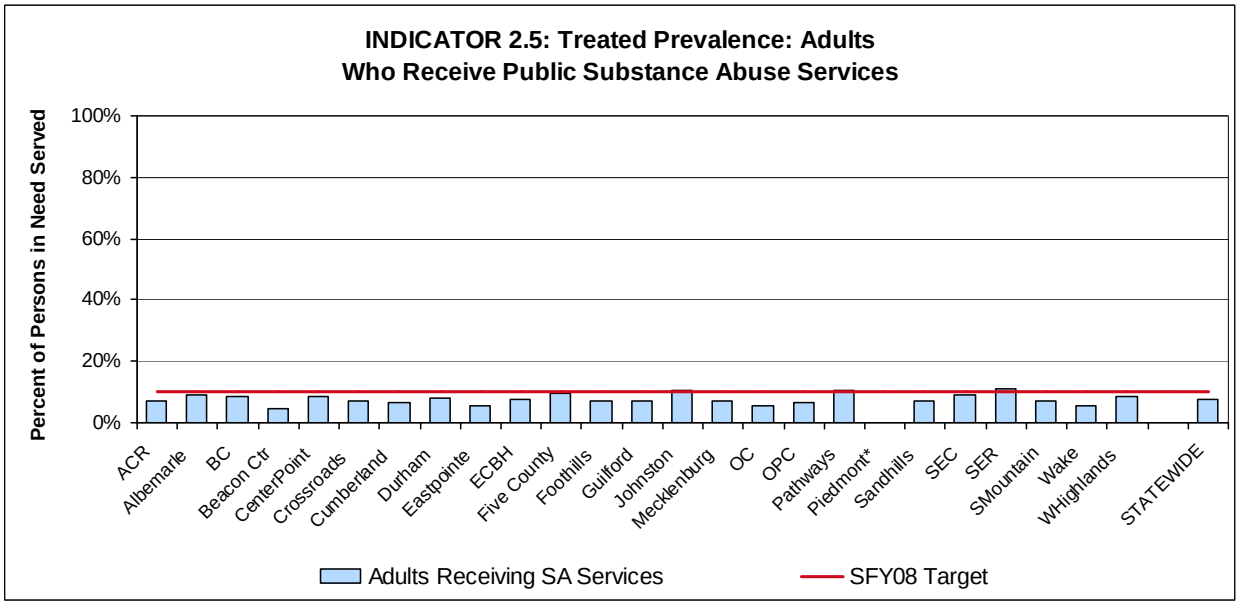
[17] The numbers reflect children and adolescents, ages 3-17, who received any DD services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private sources. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[18] The NC Division of Public Health is responsible for all services from birth through age 2. Local educational systems are responsible for educational services to children with developmental disabilities through age 21.

Indicator 2: Services to Persons in Need

2.5 Adult Substance Abuse Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. January 1- December 31, 2007; N=559,892 adults in need

Statewide, 41,512 adults (7% of those in need of services[19]) received federal or state funded SA services through our community service system from January through December 2007.[20] The rate of adults who were served varied among LMEs from a low of 4% (Beacon Center) to a high of 11% (Pathways and Southeastern Regional).

The established SFY 2008 target for persons receiving adult substance abuse services is 10%, as indicated by the red line in the graph above[21]. Of the 24 LMEs reporting, only 3 LMEs (Johnston, Pathways, and Southeastern Regional) met or exceeded the target.

[19] *State Estimates of Substance Use from the 2004-2005 National Surveys on Drug Use and Health*, Table B.20, http://oas.samhsa.gov/nsduh.htm. Age appropriate estimates applied to county population as of July 2007 (See *Appendix*).

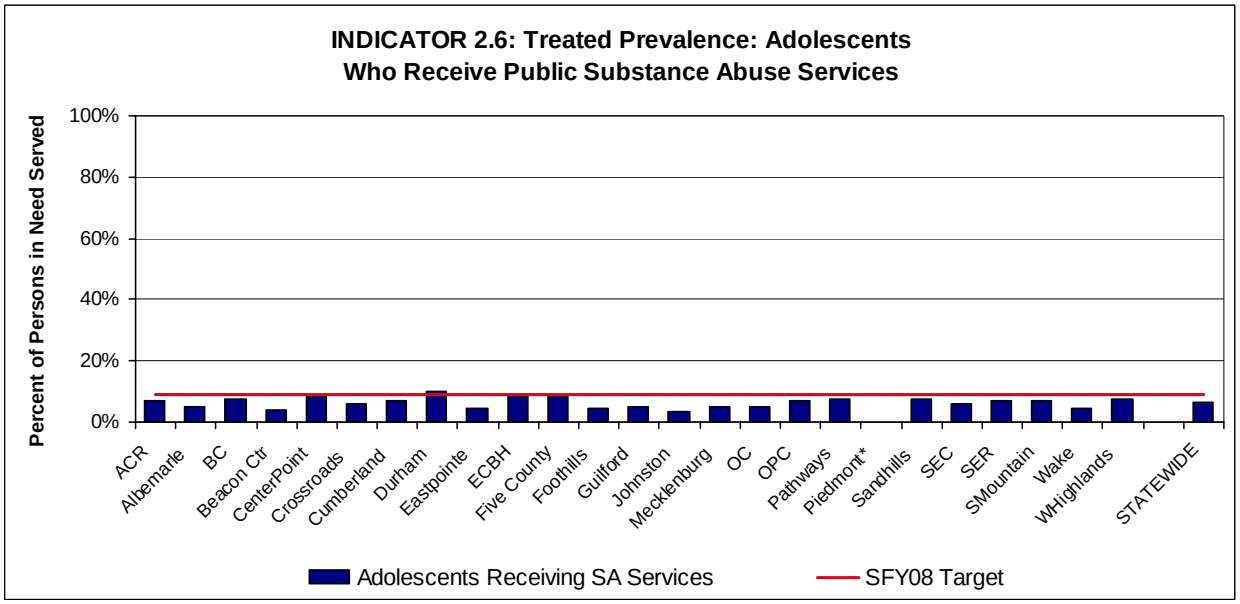
[20] The numbers served reflect adults, ages 18 and over, who received any SA services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private sources. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[21] The SFY 2008 DHHS-LME Performance Contract requirement is 8% or above.

Indicator 2: Services to Persons in Need

2.6 Adolescent Substance Abuse Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. October January 1- December 31, 2007; N=54,188 adolescents in need

Statewide, 3,442 adolescents (6% of those in need of services[22]) received federal or state funded services through our community service system from January through December 2007.[23] The rate of targeted adolescents who were served varied among LMEs from a low of 4% (Beacon Center, Eastpointe, Foothills, Johnston, and Wake) to a high of 10% (Durham).

The established SFY 2008 target for persons receiving child substance abuse services is 9%, as indicated by the red line in the graph above[24]. Of the 24 LMEs reporting, only 1 LME (Durham) met or exceeded the target.

[22] *State Estimates of Substance Use from the 2004-2005 National Surveys on Drug Use and Health,* Table B.20, http://oas.samhsa.gov/nsduh.htm. Estimates applied to county population as of July 2007.

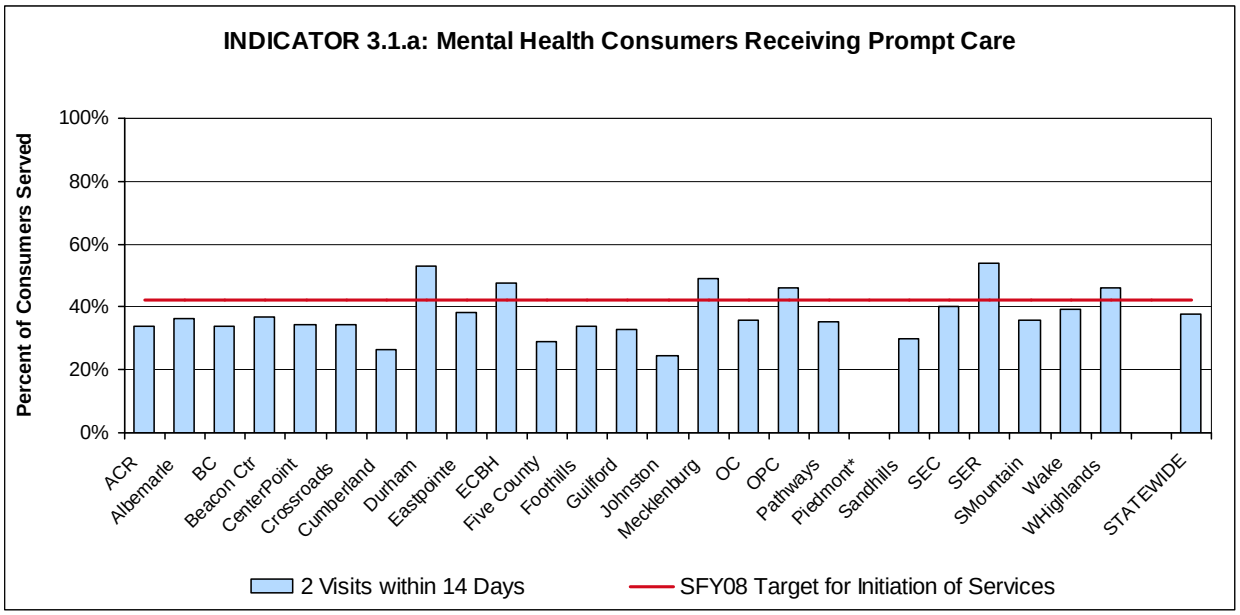
[23] The numbers served reflect adolescents, ages 12-17, who received any SA services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private sources. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[24] The SFY 2008 DHHS-LME Performance Contract requirement is 7% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.1.a Initiation of Mental Health Consumers

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. July 1 - September 30, 2007 (first service received); N=47,816 consumers

Thirty-eight percent of NC residents (all age groups) who received mental health services had two visits in the first 14 days of care, which is the standard for prompt initiation of care. Among LMEs, this percent ranges from a low of 24% (Johnston) to a high of 54% (Southeastern Regional). Compared to the other disability groups, consumers with mental illness wait longer on average for initiation of care.

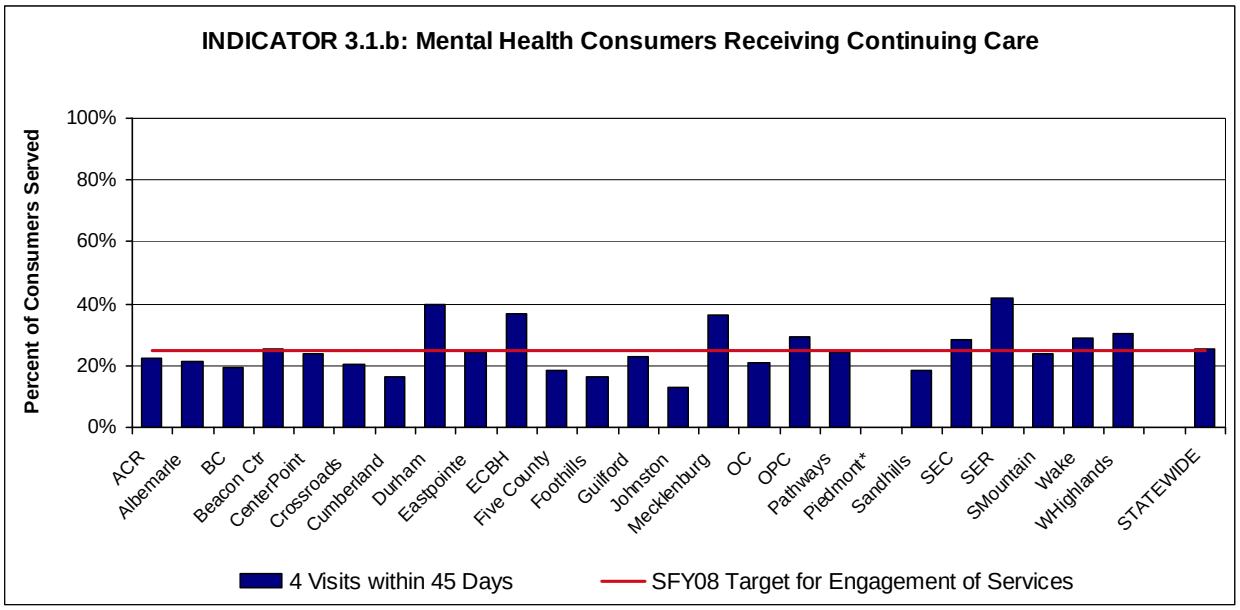
The established SFY 2008 target for initiation of mental health consumers into care is 42%, as indicated by the red line in the graph above[25]. Of the 24 LMEs reporting, only one-fourth of the LMEs (6 LMEs) met or exceeded the target.

[25] The SFY 2008 DHHS-LME Performance Contract requirement is 35% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.1.b Engagement of Mental Health Consumers

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. July 1 - September 30, 2007 (first service received); N=47,816 consumers

Slightly more than one-fourth (26%) of mental health consumers who met the initiation standard (two visits within 14 days of care) had an additional two visits within the next 30 days, making a total of four visits in the first 45 days (a best practice for full engagement in care). Among LMEs, engagement ranged from a low of 13% (Johnston) to a high of 42% (Southeastern Regional).

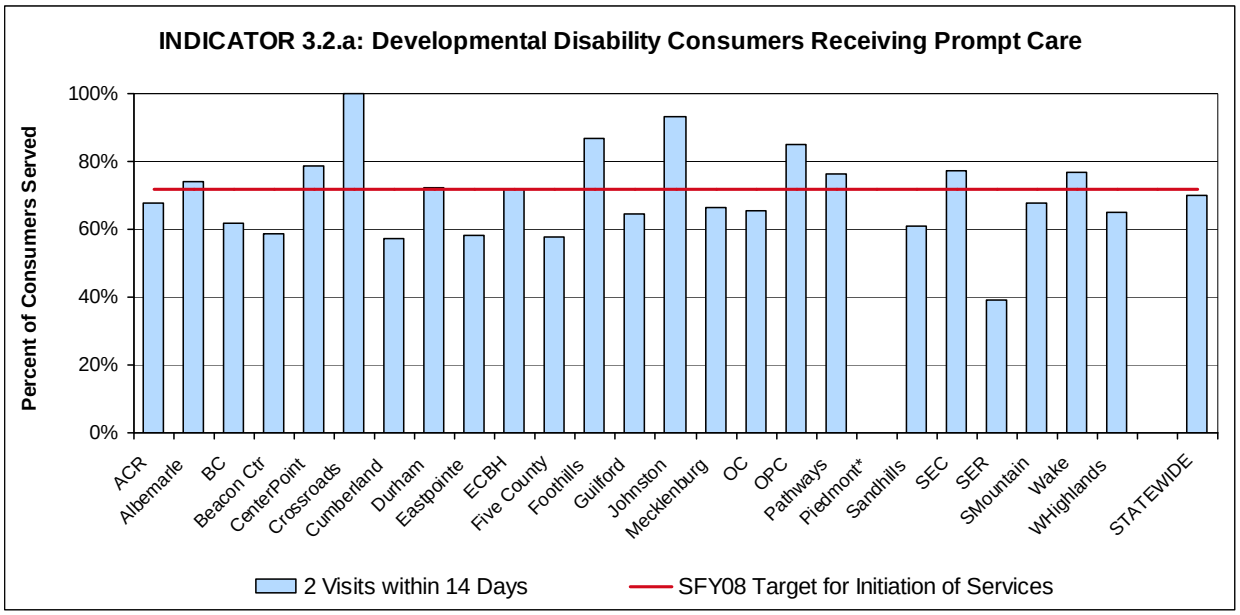
The established SFY 2008 target for engagement of mental health consumers into care is 25%, as indicated by the red line in the graph above[26]. Of the 24 LMEs reporting, slightly more than one-third of the LMES (nine LMEs) met or exceeded the target.

[26] The SFY 2008 DHHS-LME Performance Contract requirement is 21% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.2.a Initiation of Developmental Disability Consumers

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. July 1 - September 30, 2007 (first service received); N=1,046 consumers

Seventy percent of NC residents (all age groups) who received developmental disability services/supports had two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 39% (Southeastern Regional) to a high of 100% (Crosroads).

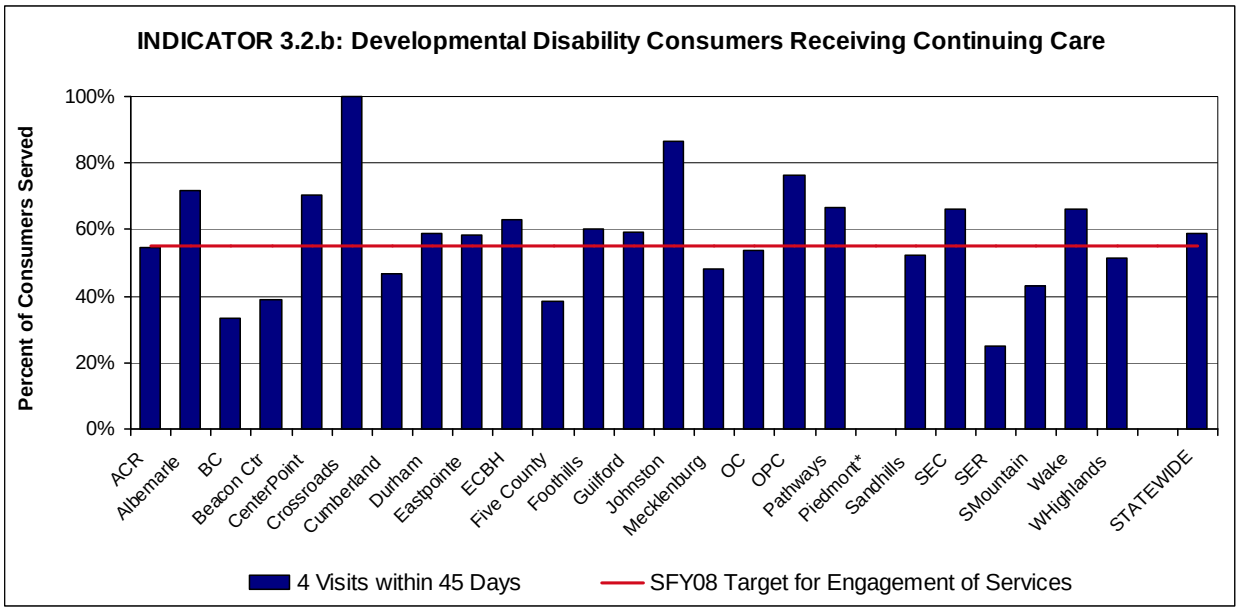
The established SFY 2008 target for initiation of developmental disability consumers into care is 72%, as indicated by the red line in the graph above[27]. Of the 24 LMEs reporting, almost half of the LMEs (11 LMEs) met or exceeded the target.

[27] The SFY 2008 DHHS-LME Performance Contract requirement is 60% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.2.b Engagement of Developmental Disability Consumers

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. July 1 - September 30, 2007 (first service received); N=1,046 consumers

Fifty-nine percent of developmental disability consumers who met the initiation standard (two visits within 14 days of care) had an additional two visits within 30 days, making a total of four visits in the first 45 days (a best practice for full engagement in care). Among LMEs, engagement ranged from a low of 25% (Southeastern Regional) to a high of 100% (Crossroads).

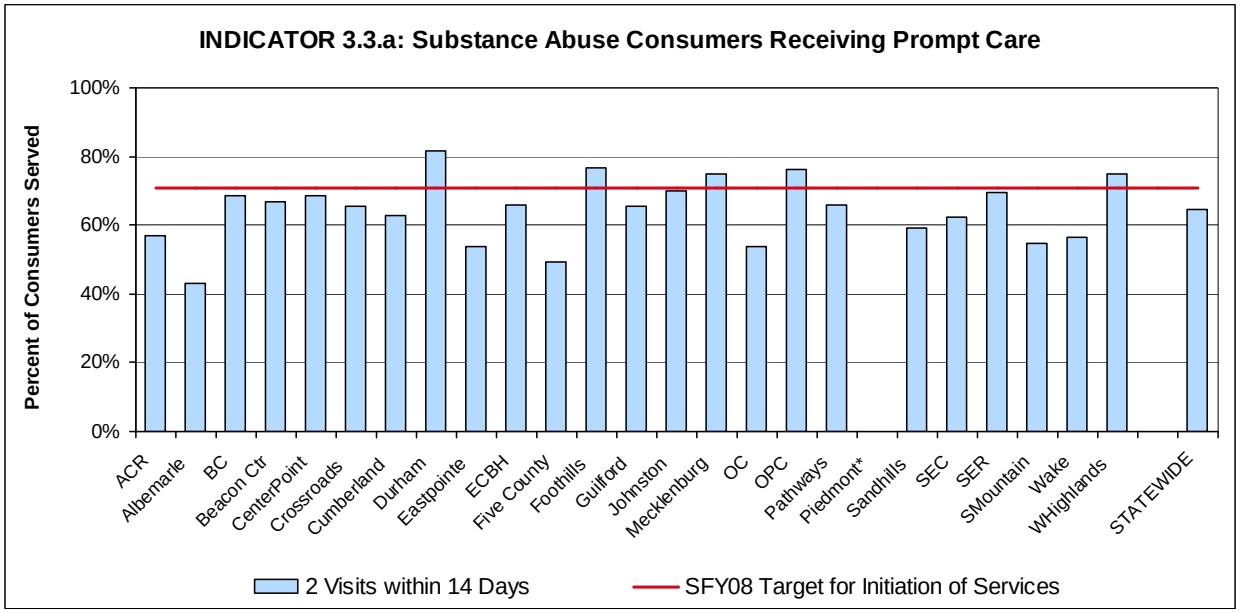
The established SFY 2008 target for engagement of developmental disability consumers into care is 55%, as indicated by the red line in the graph above[28]. Of the 24 LMEs reporting, 14 LMEs met or exceeded the target.

[28] The SFY 2008 DHHS-LME Performance Contract requirement is 46% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.3.a Initiation of Substance Abuse Consumers

Rationale: National standards[29] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. July 1 - September 30, 2007 (first service received); N=4,862 consumers

Slightly under two-thirds (64%) of NC residents (all age groups) who received substance abuse services had two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 43% (Albemarle) to a high of 82% (Durham).

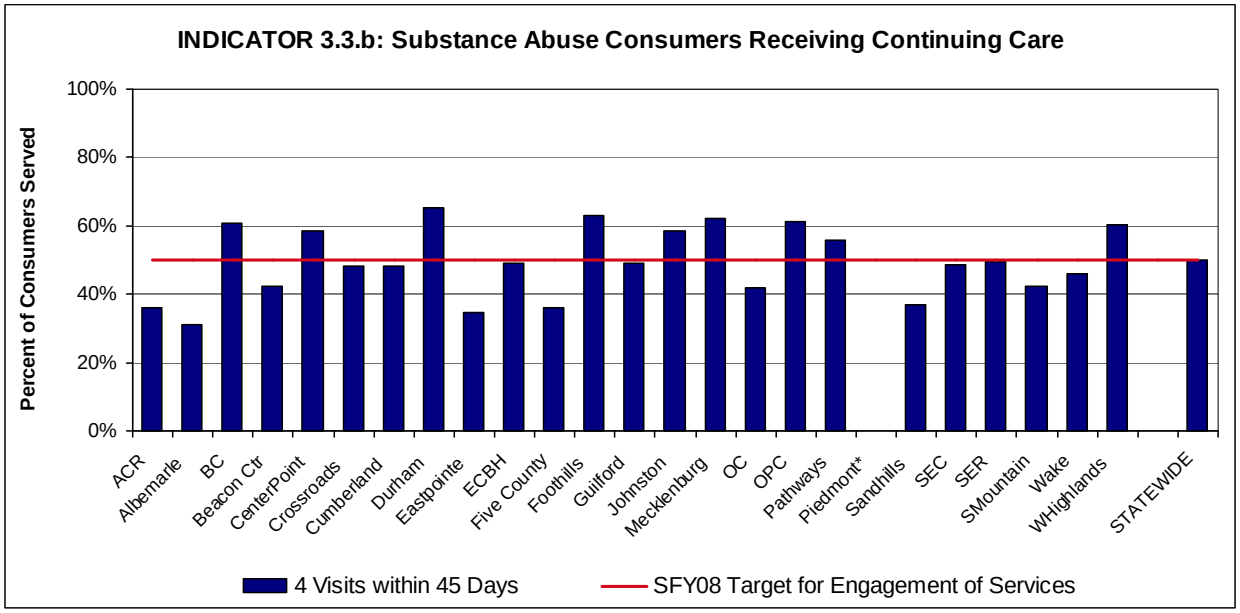
The established SFY 2008 target for initiation of substance abuse consumers into care is 71%, as indicated by the red line in the graph above[30]. Of the 24 LMEs reporting, five LMEs met or exceeded the target.

[29] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.
[30] The SFY 2008 DHHS-LME Performance Contract requirement is 59% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.3.b Engagement of Substance Abuse Consumers

Rationale: National standards[31] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. July 1 - September 30, 2007 (first service received); N=4,862 consumers

Half (50%) of substance abuse consumers who met the initiation standard (two visits within 14 days of care) had an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for full engagement in care). Among LMEs, engagement ranged from a low of 31% (Albemarle) to a high of 65% (Durham).

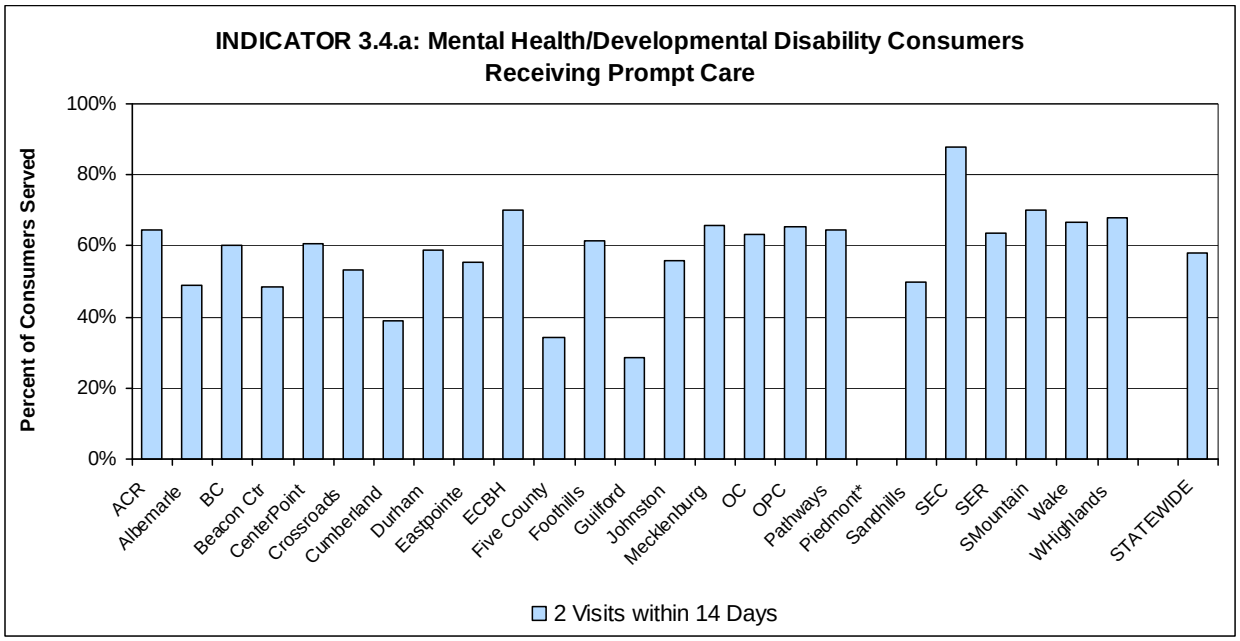
The established SFY 2008 target for engagement of substance abuse consumers into care is 50%, as indicated by the red line in the graph above[32]. Of the 24 LMEs reporting, nine LMEs met or exceeded the target.

[31] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.
[32] The SFY 2008 DHHS-LME Performance Contract requirement is 42% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.4.a Initiation of Co-Occurring Mental Health/Developmental Disability Consumers

Rationale: National standards[33] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. July 1 - September 30, 2007 (first service received); N=1,237 consumers

Fifty-eight percent of NC residents (all age groups) who received both mental health and developmental disability services had two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 29% (Guilford) to a high of 88% (Southeastern Center).

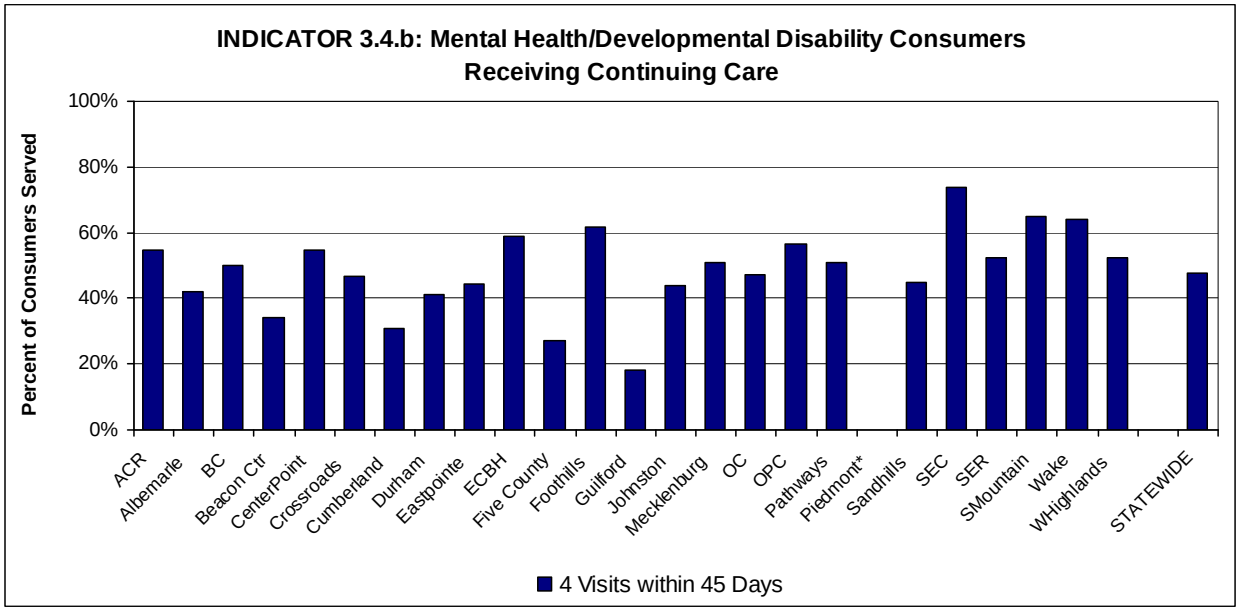
A SFY 2008 target for initiation for consumers in need of co-occurring mental health and developmental disability services has not been established.

[33] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.

Indicator 3: Timely Initiation and Engagement in Service

3.4.b Engagement of Co-Occurring Mental Health/Developmental Disability Consumers

Rationale: National standards[34] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. July 1 - September 30, 2007 (first service received); N=1,237 consumers

Less than half (48%) of NC consumers who received both mental health and developmental disability consumers met the initiation standard of two visits within 14 days and had an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for full engagement in care). Among LMEs, engagement ranged from a low of 18% (Guilford) to a high of 74% (Southeastern Center).

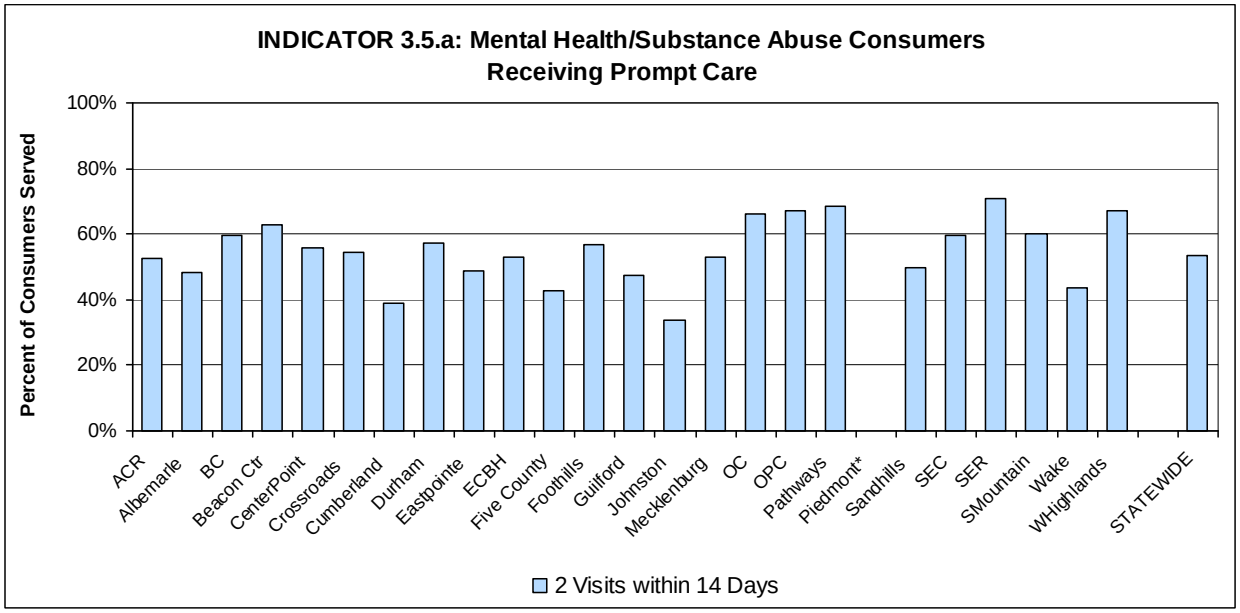
A SFY 2008 target for engagement for consumers in need of co-occurring mental health and developmental disability services has not been established.

[34] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.

Indicator 3: Timely Initiation and Engagement in Service

3.5.a Initiation of Co-Occurring Mental Health/Substance Abuse Consumers

Rationale: National standards[35] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. July 1 - September 30, 2007 (first service received); N=6,128 consumers

Just over half (53%) of NC residents (all age groups) who received both mental health and substance abuse services had two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 34% (Johnston) to a high of 71% (Southeastern Regional).

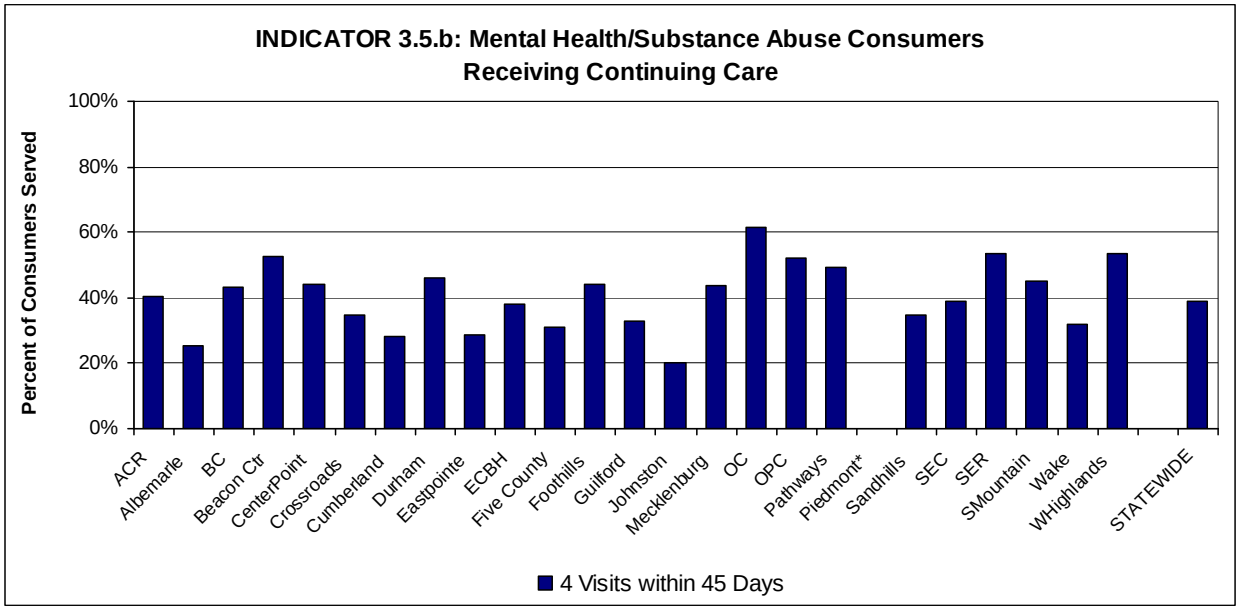
A SFY 2008 target for initiation for consumers in need of co-occurring mental health and substance abuse services has not been established.

[35] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.

Indicator 3: Timely Initiation and Engagement in Service

3.5.b Engagement of Co-Occurring Mental Health/Substance Abuse Consumers

Rationale: National standards[36] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. July 1 - September 30, 2007 (first service received); N=6,128 consumers

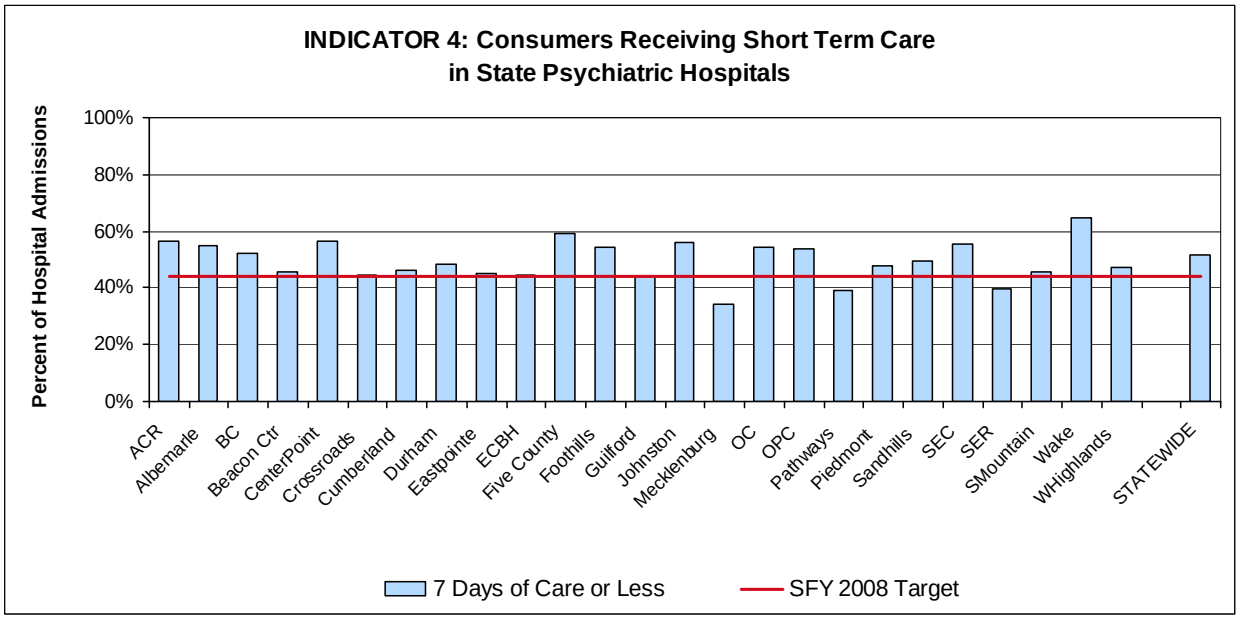
Thirty-nine percent of NC consumers who received both mental health and substance abuse consumers met the initiation standard of two visits within 14 days and had an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for full engagement in care). Among LMEs, engagement ranged from a low of 20% (Johnston) to a high of 62% (Onslow-Carteret).

A SFY 2008 target for engagement for consumers in need of co-occurring mental health and substance abuse services has not yet been established.

[36] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.

Indicator 4: Effective Use of State Psychiatric Hospitals

Rationale: State psychiatric hospitals provide a safety net for the community service system. An adequate community system can and should provide their residents with crisis services and short-term inpatient care close to home. This helps families stay in touch and reserves high-cost state facility beds for consumers with long-term care needs. *Reducing* the short-term use of state psychiatric hospitals is a goal that also allows more effective and efficient use of funds for community services.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for discharges during September 1, 2007 - March 31, 2008; N=6,050 discharges

Of the statewide hospital discharges from September 2007 through March 2008, over half (52%) were hospitalized for 7 days or less. (Note: As seen in the *Appendix*, over one-third, 34%, were hospitalized for 8-30 days). Lengths of stay for 1-7 days varied by LME from a high of 65% (Wake) to a low of 34% (Mecklenburg).

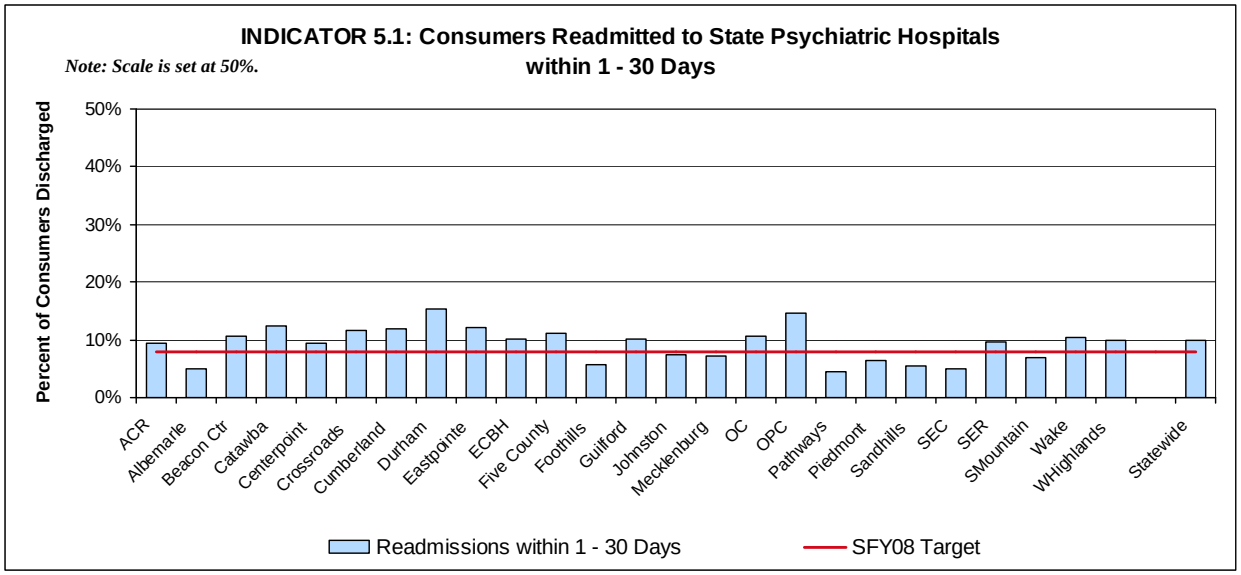
The established SFY 2008 target for short-term (7 days or less) use of state psychiatric hospitals is no more than 44%, as indicated by the red line in the graph above[37]. Of the 25 LMEs reporting, only five LMEs (Crossroads, Guilford, Mecklenburg, Pathways, and Southeastern Regional) met or exceeded the target.

[37] The SFY 2008 DHHS-LME Performance Contract requirement is 55% or below.

Indicator 5: State Psychiatric Hospital Readmissions

5.1 State Psychiatric Hospital Readmissions within 1-30 Days

Rationale: Successful community living, without repeated admissions to inpatient psychiatric care, requires effective coordination and ongoing appropriate levels of community care after hospitalization. A low psychiatric hospital readmission rate is a nationally accepted standard of care that indicates how well a community is assisting individuals at risk for repeated hospitalizations.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data (for HEARTS discharges July 1 - September 30, 2007); N=3,341 discharges

Ten percent (10%) of consumers discharged from state psychiatric hospitals were readmitted to a psychiatric hospital within 30 days. Among LMEs, the percent of consumers readmitted within 30 days varied from a high of 15% (Durham) to a low of 4% (Pathways).

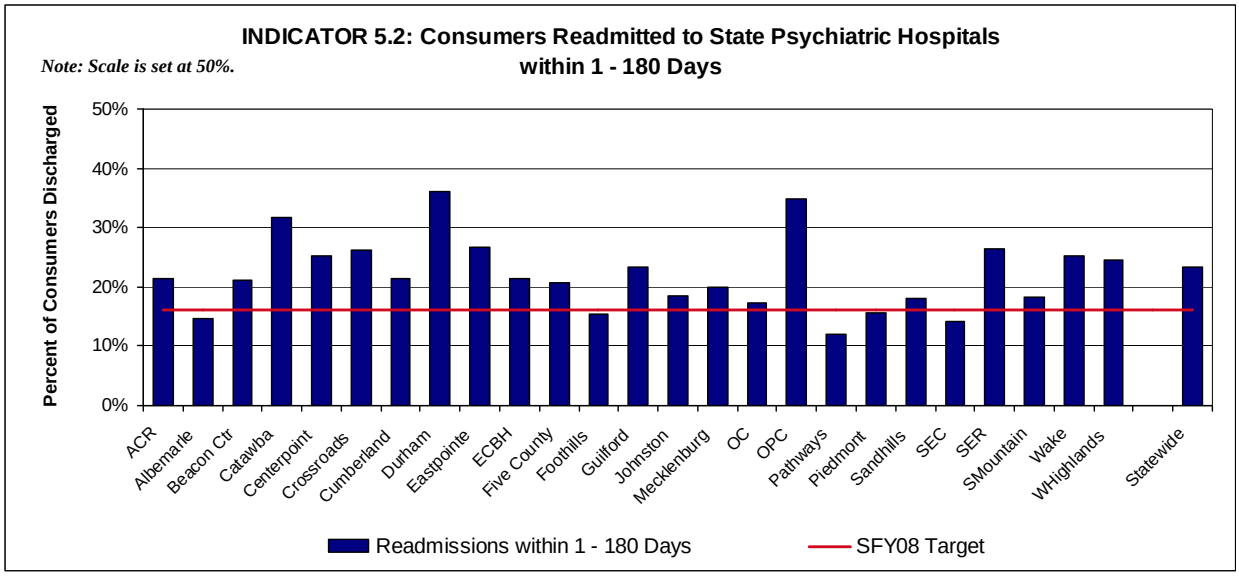
The established SFY 2008 target for readmissions within 30 days of discharge from a state psychiatric hospital is no more than 8%, as indicated by the red line in the graph above[38]. Slightly more than one-third of the LMEs (9 LMEs) met or exceeded the target.

[38] The SFY 2008 DHHS-LME Performance Contract requirement is 9% or below. Since the release of the SFY 2008 DHHS-LME Performance Contract, the methodology for calculating readmissions changed to reflect the reporting requirements for the CMHS Uniform Reporting System. The SFY 2009 DHHS-LME Performance Contract reflects this change.

Indicator 5: State Psychiatric Hospital Readmissions

5.2 State Psychiatric Hospital Readmissions within 1-180 Days

Rationale: Successful community living, without repeated admissions to inpatient psychiatric care, requires effective coordination and ongoing appropriate levels of community care after hospitalization. A low psychiatric hospital readmission rate is a nationally accepted standard of care that indicates how well a community is assisting individuals at risk for repeated hospitalizations.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data (for HEARTS discharges July 1 - September 30, 2007); N=3,341 discharges

Just under one-fourth (23%) of consumers discharged from state psychiatric hospitals were readmitted to a psychiatric hospital within 180 days. Among LMEs, the percent of consumers readmitted within 180 days varied from a high of 36% (Durham) to a low of 12% (Pathways).

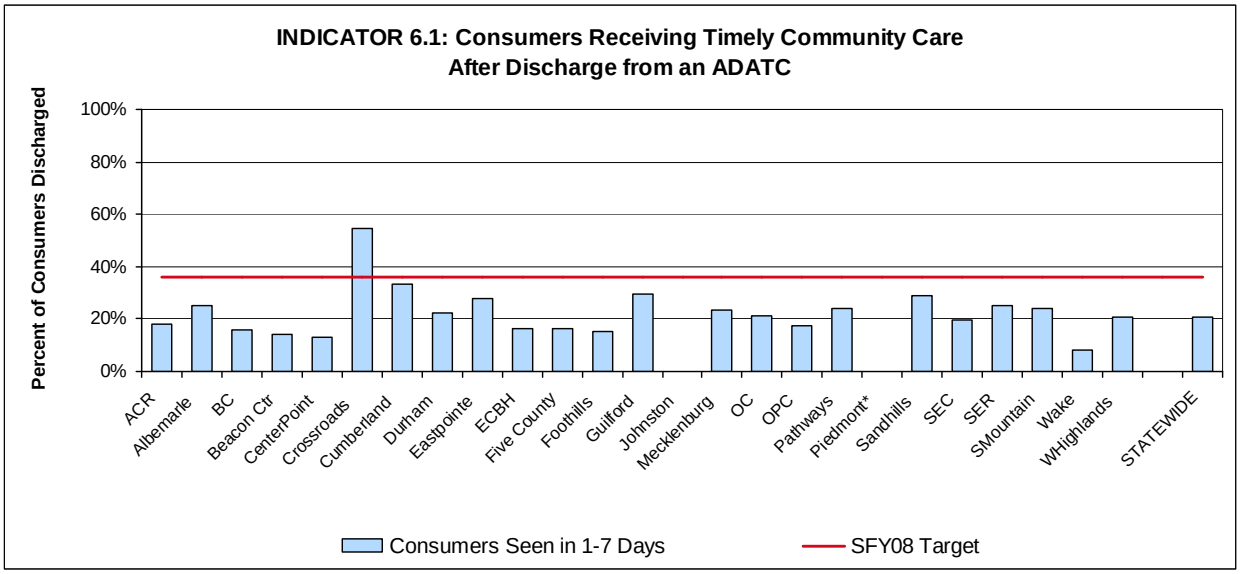
The established SFY 2008 target for readmissions within 180 days of discharge from a state psychiatric hospital is no more than 16%, as indicated by the red line in the graph above[39]. Five LMEs (Albemarle, Pathways, Piedmont, Foothills, and Southeastern Center) met or exceeded the target.

[39] The SFY 2008 DHHS-LME Performance Contract requirement is 9% or below. Since the release of the SFY 2008 DHHS-LME Performance Contract, the methodology for calculating readmissions changed to reflect the reporting requirements for the CMHS Uniform Reporting System. The SFY 2009 DHHS-LME Performance Contract reflects this change.

Indicator 6: Timely Follow-Up after Inpatient Care

6.1 ADATCs

Rationale: Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community services/ supports. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[40]



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data (for HEARTS discharges July 1 - September 30, 2007); Medicaid and State Service Claims Data (for claims submitted July 1, 2007 - March 31, 2008); N=970 discharges

Statewide, less than one-fourth (21%) of consumers discharged from an ADATC received follow-up care in the community within 7 days. An additional 12% of NC consumers were seen within 8-30 days of discharge (not shown in the graph above; see *Appendix*).

Among LMEs, the percent of consumers receiving follow-up care within 7 days varied from a low of 0% (Johnston) to a high of 55% (Crossroads).

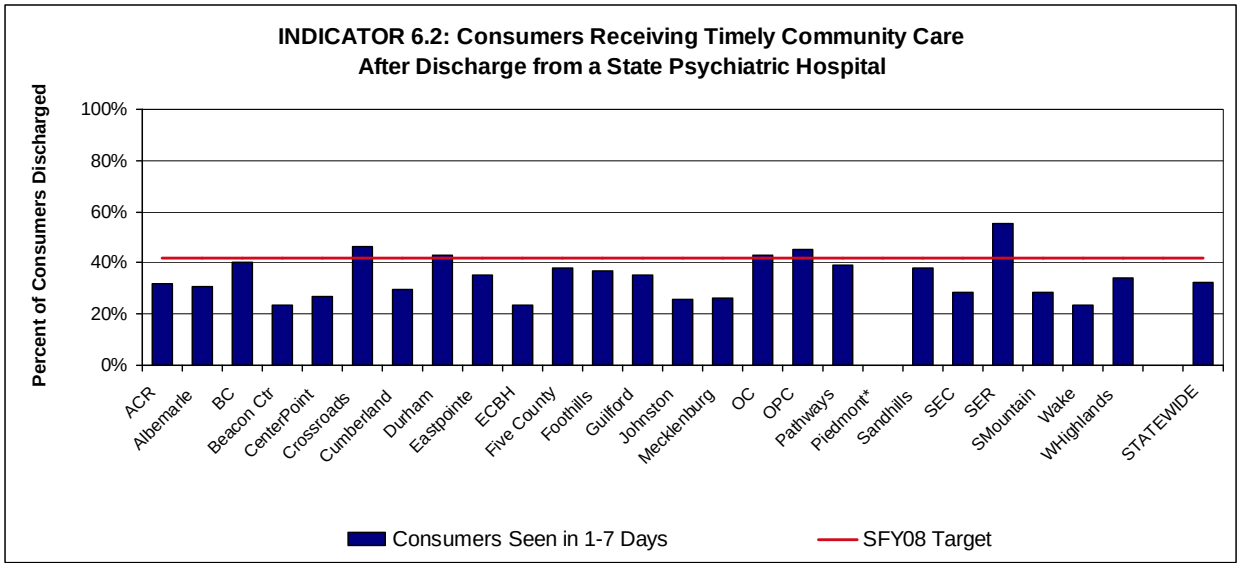
The established SFY 2008 target for follow-up care in the community within 7 days of discharge from an ADATC is 36%, as indicated by the red line in the graph above[41]. Of the 24 LMEs reporting, only 1 LME (Crossroads) met or exceeded the target.

[40] This is a Health Plan Employer Data and Information Set (HEDIS®) measure.
[41] The SFY 2008 DHHS-LME Performance Contract requirement is 24% or above.

Indicator 6: Timely Follow-Up after Inpatient Care

6.2 State Psychiatric Hospitals

Rationale: Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community services/ supports. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[42]



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data (for HEARTS discharges July 1 - September 30, 2007); Medicaid and State Service Claims Data (for claims submitted July 1, 2007 - March 31, 2008); N=3,144 discharges

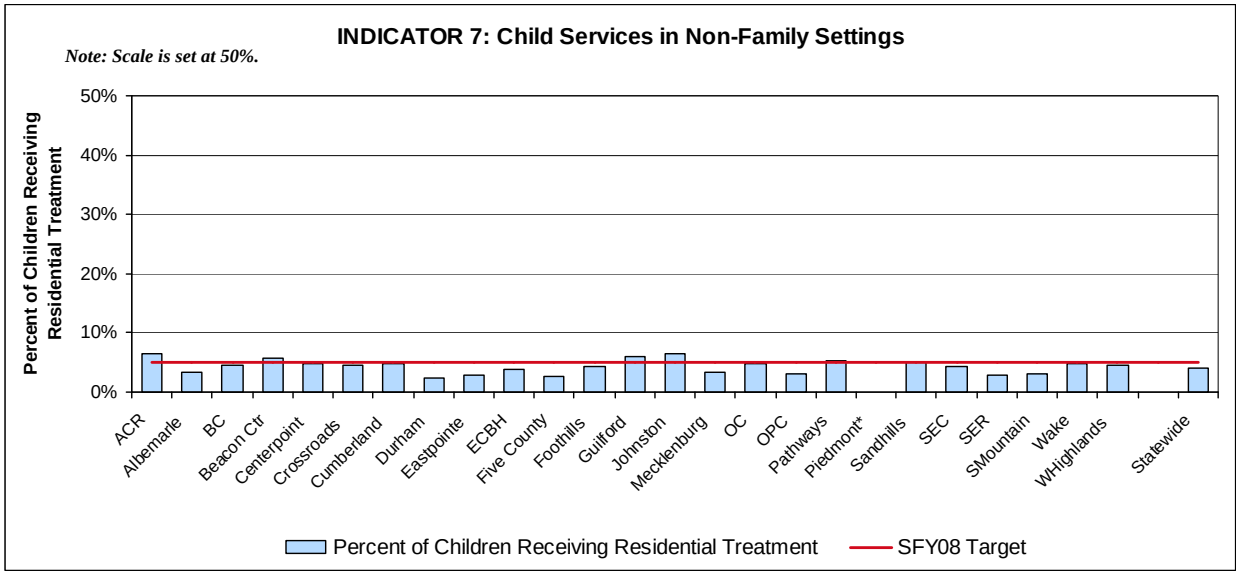
Statewide, one-third (33%) of consumers discharged from state psychiatric hospitals received follow-up care in the community within 7 days. An additional 16% of NC consumers were seen within 8-30 days of discharge (not shown in the graph above; see *Appendix*). Among LMEs, the percent of consumers receiving follow-up care within 7 days varied from a low of 23% (ECBH) to a high of 55% (Southeastern Regional).

The established SFY 2008 target for follow-up care in the community within 7 days of discharge from a state psychiatric hospital is 42%, as indicated by the red line in the graph above[43]. Of the 24 LMEs reporting, just under one-fourth of the LMEs (five LMEs) met or exceeded the target.

[42] This is a Health Plan Employer Data and Information Set (HEDIS®) measure.
[43] The SFY 2008 DHHS-LME Performance Contract requirement is 28% or above.

Indicator 7: Child Services in Non-Family Settings

Rationale: Children and adolescents served in the most natural and least restrictive community settings appropriate to their needs are more likely to maintain or develop positive family and community connections and to achieve other lasting, positive outcomes.



SOURCE: Medicaid and State Service Claims Data (for claims submitted October 1 - December 31, 2007); N=59,837 child and adolescent consumers served

Statewide, 2,464 (4%) children and adolescents receiving mental health and/or substance abuse services were served in residential settings[44]. Among LMEs, the percent of child and adolescent consumers served in residential settings ranged from a high of 7% (Alamance-Caswell-Rockingham) to a low of 3% (Albemarle, Durham, Eastpointe, Five County, Mecklenburg, OPC, Southeastern Regional, and Smoky Mountain).

The established SFY 2008 target for child services in non-family settings is no more than 5%, as indicated by the red line in the graph above[45]. Of the 24 LMEs reporting, all but four of the LMEs met or exceeded the target.

[44] Includes Level 2 (Program Type), Level 3, and Level 4 Residential Treatment Services.
[45] The SFY 2008 DHHS-LME Performance Contract requirement is 6% or below.

The MH/DD/SAS Community Systems Progress Report and the Report Appendices are published four times a year. Both are available on the Division's website:
http://www.ncdhhs.gov/mhddsas/statspublications/reports/

Questions and feedback should be directed to:
NC DMH/DD/SAS Quality Management Team
ContactDMHQuality@ncmail.net
(919/733-0696)